

ACT FOR SUICIDE PREVENTION FOR CORRECTIONAL STAFF

PERFORMANCE OBJECTIVES

1. Participants will be able to express understanding of the scope of the problem of suicide.
2. Participants will be able to identify risk factors associated with suicide.
3. Participants will be able to express understanding of steps to take when an offender/student is suspected of being suicidal.
4. Participants will know skills used for communicating with a suicidal offender/student.
5. Participants will be able to express understanding of procedures for conducting suicide watch.

US SUICIDE STATISTICS

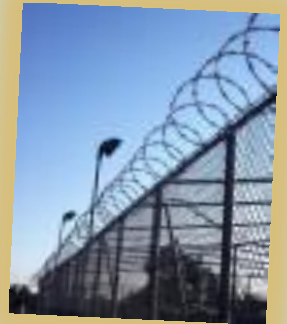
- Average of 83 suicides per day*
- 8th leading cause of death for males, 19th leading cause for females
- 4 times more men than women die by suicide
- Highest suicide rates (73%) in the U.S. = white men over age 85
- 3 times more women than men report a history of attempted suicide
- Leading method of suicide = firearms
- Estimated 8-25 attempted suicides for each suicide death

Source: National Institute of Mental Health

*Suicide Prevention Resource Center – U.S. Suicide Prevention Fact Sheet

CORRECTIONAL SUICIDE STATISTICS

- Third leading cause of death in Federal or State correctional facilities behind natural causes and AIDS
- General population – 10.7 per 100,000
- Prison population - 16 per 100,000
- Jail population - up to nine times greater than community – 43 per 100,000
- Highest suicide rates:
 - Jail inmates under age 18 = 101 per 100,000
 - Jail inmates age 55 and older = 58 per 100,000



SUICIDE STATISTICS AND MENTAL ILLNESS

- More than 90% of people who kill themselves have a diagnosable mental illness
 - Most common = Depression or Substance Abuse
- September 2006 Bureau of Justice Study found that more than half of all prison and jail inmates reported mental health symptoms
 - 56% of state prisoners
 - 45% of federal prisoners
 - 64% of local jail inmates
 - Female inmates had higher rates than male inmates



BUREAU OF JUSTICE STATISTICS SPECIAL REPORT

Report mandated by Death in Custody Reporting
Act of 2000

Data from 2000-2002 – Inmate and facility
characteristics related to high risks of suicide and
homicide

BUREAU OF JUSTICE STATISTICS

SPECIAL REPORT

Findings

- 2002, nation's smaller jails (< 50 inmates) had suicide rate 5x higher than largest jails (> 2000 inmates).
- Suicide in white inmates 6x more likely than black inmates and more than 3x more likely than Hispanic inmates.

BUREAU OF JUSTICE STATISTICS

SPECIAL REPORT

Findings

- Male suicide rate in local jails > 50% higher than female inmates
- Violent offenders suicide rate triple that of non-violent offenders
- Almost $\frac{1}{2}$ jail suicides occurred during first week in custody (7% in prisons within first month of custody)

BUREAU OF JUSTICE STATISTICS

SPECIAL REPORT

Findings

- About 80% jail and prison suicides occurred in inmate's cell – time of day not a factor
- Local jail inmates under age 18 had highest suicide rate followed by age 55 or older
- In prisons, age showed no relationship to suicide rates



Source: BJS Report, "Suicide and Homicide in State Prisons and Local Jails" – August 2005

JUVENILE SUICIDE STUDY

- Correct Care, Fall 2004 by Lindsay Hayes
- First National Survey on Juvenile Suicide In Confinement
- Study analyzed 79 out of 110 juvenile suicides, occurring between 1995-1999
- Confinement settings = Juvenile Detention Centers, Reception Centers, Training Schools, Ranches, Camps, and Farms

JUVENILE SUICIDE STUDY

■ Significant Study Findings

- Most suicides occurred at training
 - School/secure facilities or detention center
 - Length of confinement not a factor

■ Victim Characteristics

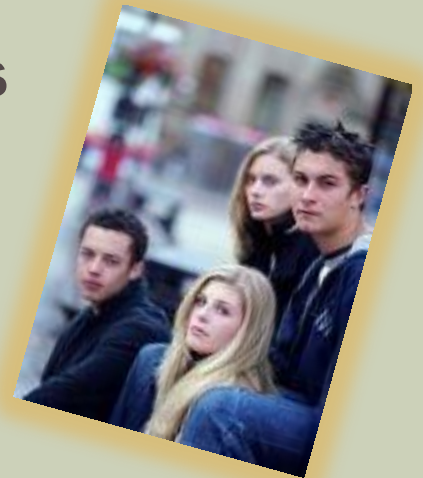
- Caucasian Male
- Average age 15.7 years (>70% between ages 15-17)
- Method = Hanging via bedding material



JUVENILE SUICIDE STUDY

■ Victim Characteristics

- Confined for non-violent offense
- History of substance abuse
- History of mental illness (mostly depression)
- History of suicide attempts/gestures
- Assigned to single occupancy rooms



Source: Correct Care, "First National Survey on Juvenile Suicide In Confinement," Fall 2004, by Lindsay Hayes

MYTH OR FACT?

- **Myth:** People who threaten suicide don't go through with it.
- **Fact:** Most people who commit suicide have made direct or indirect statements about their suicidal intentions.
- **Myth:** Suicide happens suddenly and without warning.
- **Fact:** Most suicidal acts represent a carefully thought out strategy for coping with their problems.

MYTH OR FACT?

- Myth: People who attempt suicide have gotten it out of their system.
- Fact: Any individual with one or more prior suicide attempts is at much greater risk than those who have never attempted suicide.
- Myth: Suicidal people are intent on dying.
- Fact: Most suicidal people have mixed feelings about killing themselves; they are doubtful about living, not intent on dying. **MOST WANT TO BE SAVED!**

MYTH OR FACT?

- Myth: Asking offenders about suicidal thoughts or actions will cause them to kill themselves.
- Fact: You cannot make someone suicidal when you show an interest in their welfare by discussing the possibilities of suicide. Concerned, non-judgmental questions encouraging the person to discuss his/her ideas may help relieve the psychological pressure.
- Myth: All suicidal individuals are mentally ill.
- Fact: A suicidal person is extremely unhappy but not necessarily mentally ill; a “normal” person can be suicidal.

KEEP IN MIND

Correctional facilities may seem like an unlikely place to commit suicide, however, the incarcerated individual has limited control, few options, and their future is more unpredictable.

Result = Hopelessness which may lead the offender/student to see suicide as the only way to deal with his/her problems

WHAT DOES A SUICIDAL PERSON LOOK LIKE?



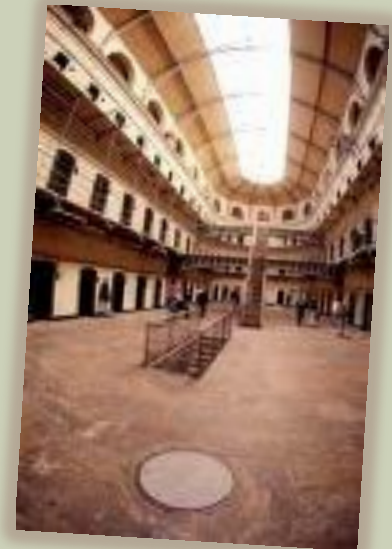
CORRECTIONS ENVIRONMENT RISK FACTORS

- **Factors Increasing Suicide Risk**
 - Authoritarian environment is unfamiliar
 - Loss of control over future
 - Isolation from family, friends, community



CORRECTIONS ENVIRONMENT RISK FACTORS

- **Factors Increasing Suicide Risk**
 - Shame of incarceration
 - Dehumanizing aspects of confinement
 - Fears due to media and self-imposed stereotypes
 - Staff insensitivity to inmate's situation – especially for first-time arrestee



OFFENDER/STUDENT RISK FACTORS

- History of self-harm acts - especially suicide attempt while confined
- Intoxication and/or withdrawal and/or substance abuse history
- Recent loss (Loved one, job, home, finances)
- Juvenile
- Sex offender

OFFENDER/STUDENT RISK FACTORS

- Segregation and/or Isolation from others
- Segregation increases risk of psychological difficulties – especially in the mentally ill and juveniles
- Family history of suicide
- Mental illness – especially depression



OFFENDER/STUDENT RISK FACTORS

- First offense
- Long sentence
- Violent history
- Shame or stigma associated with crime
- Publicity



OFFENDER/STUDENT RISK FACTORS

- Public figure or “Pillar of Society”
- Fear of same-sex rape or threat of it
- Poor physical health
- Difficulties with staff or other inmates



OFFENDER/STUDENT RISK FACTORS

- Gambling debts, drugs
- Ending of close relationship with another offender
- Working the system to be celled alone, i.e., requesting Protective Custody, threatening cellmate, etc.
- Consider that offenders requesting PC or demanding to be celled alone may be contemplating suicide

HIGH RISK PERIODS DURING INCARCERATION

- First 24 hours
- Withdrawal from alcohol or drugs
- Awaiting Trial
- Sentencing
- Additional Charges
- Longer/More severe sentence than expected
- Repeat Offender - knows what to expect in prison
- Impending release



HIGH RISK PERIODS DURING INCARCERATION

- Holidays
- Darkness
- Decreased staff supervision (weekends, nights, holidays, shift change)
- Bad news (breakup, home foreclosure, death notice, no-show visitor, etc.)
- Receipt of Disciplinary Report

PHYSICAL ILLNESS RISK FACTORS

- Chronic and debilitating illnesses can increase the risk for suicide in some people
- Examples of illnesses are:
 - HIV/AIDS
 - Cancer
 - Chronic pain
 - Long-term dialysis for kidney failure

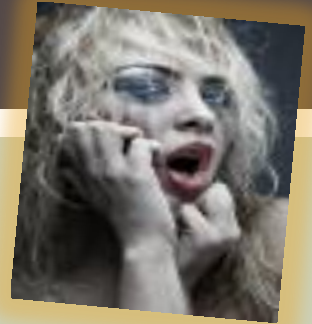


SUICIDE WARNING SIGNS

- Depression or Paranoia
- Expresses guilt/shame over offense
- Statements about suicide or death
- Self-harm attempts
 - Each attempt should be taken seriously!



SUICIDE WARNING SIGNS



- Severe agitation or aggression
 - Agitation often precedes suicide
 - Suicide can be a possible means to relieve agitation
- Hopeless/pessimistic about future
- Extreme concern or anxiety over what will happen to them
- Appetite and sleep changes

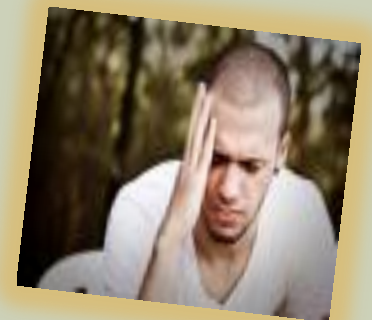
SUICIDE WARNING SIGNS

- Mood/behavior changes
 - May refuse treatment
 - Withdraws from others, may demand to be celled alone
 - Neglects personal hygiene or appearance
- Preoccupied with past – doesn't deal well with present
- Packing/giving away belongings



SUICIDE WARNING SIGNS

- Writes a will
- Hallucinations and Delusions
 - May hear voices or see visions that tell inmate to harm self
- Vulnerable offender/student at facility with recent suicide or attempt – “Copycat” phenomenon



SUICIDE PREVENTION OBSTACLES

Negative Attitudes

“If an offender really wants to kill himself, there’s really no way to prevent it.”

“This was a behavior issue, acting out, that went too far.”

“Suicide prevention is a medical/mental health problem. It’s not my problem.”

Source: Lindsay Hayes, National Center on Institutions and Alternatives/Project Director, Jail Suicide/Mental Health Update Newsletter and “Suicide Detection and Prevention in Jails and Lockups” Training Curriculum 1995

COMMUNICATING WITH SUICIDAL OFFENDERS

1. Listen Patiently

- Encourage offender/student to talk, including about suicide plan

2. Trust Your Own Judgment

- If you believe offender/student is in danger of suicide, implement suicide prevention protocols and keep offender/student in a safe place

COMMUNICATING WITH SUICIDAL OFFENDERS

3. Maintain Contact

- Address offender/student by name
- Don't be reluctant to express your concerns about the offender/student
- Eye contact - Show concern, not disapproval or disgust

4. Try To Keep Offender's/Student's Sense of Future Positive

- Focus on programs available to offender/student, i.e., school, vocational training, substance abuse, etc.
- Support from family and friends that care

RESPONDING TO THE SUICIDAL OFFENDER

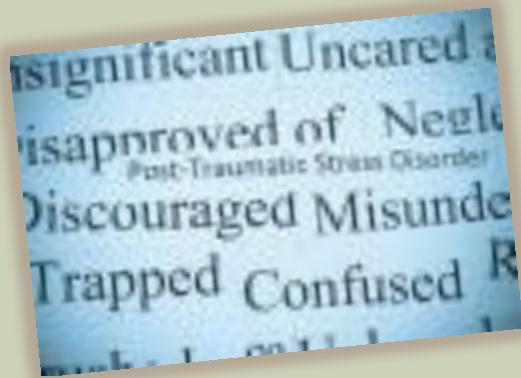
TAKE ALL THREATS SERIOUSLY!

- Don't ignore threat because you think the offender/student is simply acting out
- It is not the officer's responsibility to decide whether the threat is genuine or "fake" – diagnosis is the duty of the mental health professional
- Always refer potential suicide threats immediately to the mental health professional for evaluation and determination of level of suicide risk



RESPONDING TO THE SUICIDAL OFFENDER

- Place offender/student in a safe environment where he/she is **not left alone** until a mental health professional can assess level of suicide risk
 - Know your facility procedure for placement and correctional officer monitoring of offenders/students awaiting evaluation by Mental Health
- Remember – Accidental deaths do occur in offenders/students who were allegedly “acting out” by threatening suicide



**Suicide attempt #99 should be
treated as seriously as #1!**



WHAT NOT TO DO

1. Don't offer solutions or give advice
 - Don't try to make a diagnosis
 - Staff's job is to report signs of suicide risk
2. Don't become angry, judgmental, or threatening
3. Don't be sarcastic, make jokes, or tease



WHAT NOT TO DO

- Don't make promises that can't be kept
- NO REVERSE PSYCHOLOGY – Don't challenge the offender/student to make good on threat of suicide
- Never ignore the risk or threat – offenders/students can become suicidal at any point during incarceration



REPORT AND REFER YOUR OBSERVATIONS TO MENTAL HEALTH STAFF



It is the duty of mental health staff to diagnose and treat the offender/student.

INTAKE SCREENING

All offenders/students will be screened for suicide risk at intake immediately upon arrival. Facility staff receiving a new offender/student will obtain information regarding conduct and demeanor during transport from the transporting officer or staff. Information obtained from transporting staff must be recorded on the “Point of Entry” form (State Form 45998). Facility staff in the intake area must not rely on an offender’s/student’s denial that he/she is suicidal; any behavior or actions which suggest the offender/student is at risk of suicide or self-injurious behavior must be documented and nursing staff notified.

ALL STAFF NEED TO KNOW...

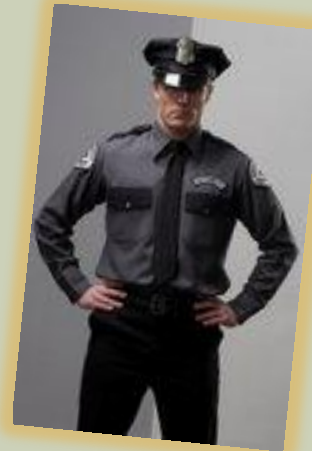
- Facility Policy and Procedure for Suicide Watch
- Which cells are designated for offenders on suicide watch? (NOTE: SAFE CELL CHECKLIST)
- What clothing, bedding, property, and meals are allowed for offenders/students on suicide watch?
- What are the levels of suicide watch?
 - Close Observation and Constant Observation



ALL STAFF NEED TO KNOW...

- How often must the officer check on the offender/student on each level of suicide watch?
- How and where does the officer document results of suicide watch?
- How does custody staff contact mental health during and after business hours?

**If you're at work, you're on
watch....**



**Preventing suicide is the
responsibility of all staff
24/7**

SUICIDE WATCH CONSIDERATIONS

- Communicate every day with mental health staff during daily suicide watch rounds. Mental health staff want to know:
 - Is offender/student eating meals?
 - Is offender/student sleeping normally?
 - Offender's/student's behavior when awake?
 - Is offender/student attentive to personal hygiene?
 - Does offender/student communicate appropriately with officers and other offenders/students?
- Remember - Suicide Watch is discontinued only by a mental health professional!



RESPONDING TO AN ADULT HANGING

1. First staff person on scene will conduct visual assessment of offender from outside the cell to determine if offender has article around neck and is attempting to hang self.
2. First staff person on scene shall stay at cell front to observe and summon another Officer via radio for assistance.
3. First staff person on scene shall contact Main Control and announce "Signal 3000" on radio and observe offender's hands for possible weapons.



RESPONDING TO AN ADULT HANGING

4. Immediately upon arrival of at least one (1) Correctional Officer (minimum of two [2] staff must be present), staff will enter the cell.
5. Both staff will lift the offender up and one (1) staff member will cut the offender down with the designated cutting device
 - This device is to be located in all secured control rooms and official stations in individual housing units.
6. The First Responders OIC will be responsible to ensure the cutting device is ready for use at incident area.

RESPONDING TO AN ADULT HANGING

7. The offender will be laid on the floor (hard surface if possible) and the article around his/her neck removed.
8. Officers/staff will begin basic life-saving techniques.
9. When medical assistance arrives, health care staff will assume the lead role in life-saving techniques assisted by Officers/staff if necessary.



ADULT OFFENDER UNRESPONSIVE

1. First staff person on scene will conduct a visual assessment from outside cell to determine if offender is not responding to any questions about his/her condition and appears to be either unconscious or experiencing a medical emergency.
2. First staff member on scene shall remain at the cell front to observe offender, call Main Control and announce a "Signal 3000".

ADULT OFFENDER UNRESPONSIVE

3. First staff on scene will observe offender's hands for any objects that may be weapons.
4. While waiting, staff person on scene will contact Shift Supervisor via radio, if possible, and request to go to specified "Tac Channel" to inform them of unresponsive offender's condition and location.
5. Shift Supervisor will quickly make a determination of the appropriate response. (If the Shift Supervisor's directions are different than those listed below, a written justification will be required after the incident is over)

ADULT OFFENDER UNRESPONSIVE

6. Once a minimum of two (2) staff persons (at least one [1] Correctional Officer) have arrived at cell, the door will be opened and staff shall enter the cell.
7. Staff will enter the cell with caution and be prepared to use an O/C streamer, but move quickly to secure a hold on offender's arms.
8. Restraints will not be applied to the offender's hands, instead one (1) staff will secure the offender and the other staff person will assess the offender and begin life-saving measures.

ADULT OFFENDER UNRESPONSIVE

9. The above procedures shall be followed in all Disciplinary and Administrative Restrictive Housing, as well as Special Needs Units, with the following additions:
- All first responders entering cells on these units shall wear a vest, helmet and gloves which shall be staged on units for quick access; and,
 - Mechanical restraints shall be applied minimally on the offender's hands in front of the offender.

ADULT OFFENDER UNRESPONSIVE

- 10.** All appropriate reports shall be completed prior to staff leaving the facility at the end of the shift and shall be submitted to the Custody Supervisor for review by appropriate staff.



STUDENT ATTEMPTING SUICIDE OR UNRESPONSIVE

- First staff person on scene will radio for assistance.
- Once the staff person has radioed for assistance, the staff person shall immediately enter the cell and provide first aid and CPR, if necessary.
- Facility staff shall not wait for back-up staff, including nursing staff or external emergency services staff, to arrive before entering a cell and initiating appropriate life-saving measures.
- When entering a room/area under these conditions, staff should remain alert and aware due to the inherent dangers that can be associated with this type of situation.



SUICIDE THREATS, SELF-INJURY, AND BEHAVIORAL ISSUES

- Suicide threats and engaging in self injury for secondary gain are common in the correctional setting.
- “Faked” suicide attempts often end up as deaths!
- There must be a thorough evaluation by Medical and Mental Health to determine whether the offender’s/student’s behavior is due to a serious medical and/or mental health condition.
- Certain medical illnesses can cause unusual behaviors.

SUICIDE THREATS, SELF-INJURY, AND BEHAVIORAL ISSUES

- Once serious mental and/or medical illness have been ruled out by healthcare professionals, acting-out behaviors can be addressed via a behavioral management plan
- Mental health staff can provide guidance to the multidisciplinary team in developing plans for individual offenders/students
- All disciplines working together, including custody, is critical to effective treatment planning!

TEAMWORK

Successful Suicide Prevention must be a team effort between healthcare and correctional staff



CONCLUSION

- Correctional staff are the foundation for suicide prevention efforts
- YOU form the bridge of communication with potentially suicidal offenders/students by:
 - Observing daily offender/student behaviors
 - Interacting with and listening to offenders/students
 - Reporting concerns to medical/mental health staff promptly

**For all that you do to prevent suicide at
your facility...**

Thank You!



**You have now completed the module on,
“Suicide Prevention & Intervention.”**

**If you have any questions, please contact your
Community Involvement Coordinator.**

Staff Development and Training